THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO: 453-04-5201.M5

MDR Tracking Number: M5-04-1037-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 1-29-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the prescription medication Hydrocodone was not medically necessary.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service 9/25/03 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 18th day of March 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division
RLC/rlc

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M5-04-1037-01
IRO Certificate Number: 5259

March 11, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in family practice. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY
___ sustained a work related injury of both feet on ___. He received extensive evaluation and treatment including X-rays, MRIs, medications, multiple surgeries, cortisone injections, and a work hardening program.

REQUESTED SERVICE (S)
Hydrocodone.

DECISION
Uphold previous denial.

RATIONALE/BASIS FOR DECISION
Unfortunately, this patient has failed exhaustive conservative and surgical treatment. He is currently a chronic pain patient. Accepted literature and guidelines recommend avoiding narcotics in chronic pain patients because of potential long term side effects and addictive properties. At this point, non-narcotic analgesics are more appropriate for long term use for this chronic problem. Therefore, the prior denial is upheld.